GIMBEL EYE CENTRE®

Refractive Surgery Assessment & Referral

PLEASE PRINT/TYPE & COMPLETE BOTH SIDES OF FORM

Assessment Date (m/d/y): _____

Patient Name (Dr./Mr./Mrs./Ms./Miss): _____ Sex: ☐ Female ☐ Male

DOB (m/d/y): _____ Alberta Health Care #: _____

Address: _____ E-mail: _____

Telephone (res): _____ Telephone (bus): _____ Telephone (cell): _____

City: _____ Prov/State: _____ Postal/Zip: _____

Name of Doctor Assessing: _____ Type of doctor: ☐ OD ☐ MD ☐ OPH

Address: _____ # of years patient has been in your care: _____

Telephone: _____ Facsimile: _____

City: _____ Prov/State: _____ Postal/Zip: _____

Patient Health History

Ocular History (e.g., Injury, Amblyopia, Previous Eye Surgery Dry Eye, Motivation for surgery, etc.): _____

Medical History: _____

Please Check:

☐ Diabetes	☐ Collagen Vascular Disease	☐ Mobility Problem	☐ Heart
☐ Asthma	☐ Auto Immune Disease	☐ Immune Deficiency	☐ Language Difficulty
☐ Hepatitis	☐ Ocular Herpes Zoster	☐ Ocular Herpes Simplex	☐ Hearing Difficulty
☐ Atopy	☐ Pregnancy/Nursing	☐ Benign Prostatic Hypertrophy	☐ Hypertension

☐ Other health problems or concerns (If YES, please specify): _____

List Medications, include Imitrex® (migraine), Accutane® (acne), Amiodarone® (cardiac anti-arrhythmic) &/or Flomax® (urinary flow):

Ocular: _____ Systemic: _____

List allergies to food (include nuts and shellfish), medications, surgical tape, eye drops, iodine &/or latex: _____

Specify if: ☐ Airborne ☐ Contact

Eye Colour: _____ Eye Dominance: ☐ OD ☐ OS

Current Spectacles Rx OD _____ OS _____

Does the patient wear prism(s) in his/her current spectacles? ☐ Yes (If Yes, an orthoptic exam may be required) ☐ No

Current Contact Lens Rx OD _____ OS _____

If contact lenses are worn, indicate: ☐ Hard ☐ Soft ☐ RGP ☐ Other, please specify: _____

☐ Instructed to leave out contact lenses for _____ days prior to surgery

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Refractive Surgery Assessment & Referral cont'd

	OD	OS
Refraction & VA Date, if other than today:		
Cycloplegic & VA Date, if other than today:		
Vertex distance of above readings		
Keratometry Readings ☐ Manual ☐ Auto	@ @	@ @
Intraocular Pressure ☐ NCT ☐ AT	mm Hg	mm Hg
Pupil Size (Diameter in room & dim illumination)	mm (Room) mm (Dim)	mm (Room) mm (Dim)
Pupil Reactions: PERRL Other:		
Stereopsis	Seconds of Arc	
Anterior Segment	Normal/Other	Normal/Other
Posterior Segment ☐ Dilated ☐ Undilated		
C/D (Cup-to-disc ratio)		
Macula		
Periphery		
Pachymetry		
Corneal Diameter		

Monovision Discussed ☐ Yes ☐ No

Monovision Trial ☐ Yes ☐ No

Summary (include summary of patient education):

Signature of Assessing Doctor: PRACID#:

For GEC Office Use Only

Patient ID:

Surgeon Comments:

☐ Gimbel Eye Centre Calgary Fax: (403) 202-3303 ☐ Gimbel Eye Centre Edmonton Fax: (780) 452-4114